

June 27, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1605-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted electronically

RE: CMS-1605-P; Medicare Program - Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2015

Dear Administrator Tavenner:

On behalf of the 88,000 physical therapist, physical therapist assistant, and students of physical therapy members of the American Physical Therapy Association (APTA), I would like to submit the following comments in response to the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Fiscal Year (FY) 2015 proposed rule. Physical therapy is an integral service provided to Medicare beneficiaries in the SNF setting. Physical therapists furnish medically necessary services to patients in the SNF to improve their overall health, function and to optimize their quality of life.

The estimated SNF market basket update to payments for FY 2015 is 2.0 percent after applicable adjustments. We commend CMS for proposing an increase in payment for SNF services in FY 2015. A robust set of resources are needed to treat this critically complex population of patients. Therefore, we wholeheartedly support the finalization of the positive payment update.

While, we support the overall proposed policies included in this rulemaking, we respectfully request that you consider the comments and recommendations provided below. In summation, APTA:

- 1) Supports continued efforts to overhaul the therapy payment methodology component of the SNF PPS. Specifically, APTA appreciates the selection of a payment model based on patient characteristics and resource needs as a starting point for further work.**

- 2) **Strongly urges CMS to incorporate development of a core item set that can aid in collection of data across all post-acute care settings as a component of the SNF Therapy Research Project.**
- 3) **Requests that CMS provide more detail regarding the proposed payment models and plans for phased-in implementation prior to publication of the FY 2016 proposed rule.**
- 4) **Supports the finalization of the proposed revisions related to the Change of Therapy (COT) Other Medicare Required Assessment (OMRA) as we believe this will help to more accurately categorize patients in the applicable Resource Utilization Group for payment purposes and minimize administrative burden on SNFs.**
- 5) **Requests that CMS provide educational resources to providers such as a Frequently Asked Question document and MLN article to fully explain how this change will affect SNF assessments.**
- 6) **Commends CMS and the Office of the National Coordinator on the promotion of health information exchanges and states APTA's commitment to work with the federal government on implementation within the physical therapy profession.**

SNF Therapy Research Project

CMS contracted with Acumen, LLC to identify and evaluate potential alternatives to therapy reimbursement for the skilled nursing facility (SNF) prospective payment system (PPS). The initial findings and proposed recommendations are laid out in a report released in conjunction with the SNF PPS FY 2015 proposed rule. The report explores four alternatives: a patient characteristics model, a hybrid model that blends patient characteristics and a resource-based pricing adjustment, a fee schedule, and a competitive bidding model.

The patient characteristics model uses information, such as medical, functional, or cognitive status, to group patients with similar clinical characteristics and expected cost of care to determine payment levels. The hybrid model classifies patients based on condition and diagnosis and pairs it with a pricing adjustment based on expected resources. The fee schedule model bases payment on the patient's actual therapy use rather than expected resource use. The competitive bidding model allows market-based pricing of therapy services through a bidding process.

Acumen recommends using the patient characteristics and hybrid model concepts as the basis for development of a final model. CMS will now develop these two concepts for implementation. Model development will take place in four stages: developing an analysis plan, conducting empirical analyses, soliciting and incorporating feedback from a technical expert panel, and summarizing findings.

Overall, APTA supports the work of this project and CMS' efforts to reconstruct therapy payment under the SNF PPS. Specifically, we agree that a model based on patient characteristics is a step in the right direction. We particularly appreciate the efforts to use the resident assessment items developed during the Post-Acute Care Payment Reform Demonstration (PAC-PRD) to develop the model. Secondly, we agree with the general concept to incorporate resource use into the payment model design. Although, we do caution CMS not to heavily focus on measures of resource utilization such as the number of therapy minutes as this is a cornerstone of the current payment structure that we believe poses unwanted financial incentives. Alternatively,

we believe that resource use should be based on other factors such as staffing, equipment and supply needs and other operating costs of the SNF.

We believe this new payment methodology should be crafted for applicability and possible implementation in the other prospective payment systems (PPS') such as home health and inpatient rehabilitation. Transitions in care and continuity between Medicare post-acute care benefits should allow for seamless delivery of therapy services. Therapists are integral in transitions in care and should be heavily relied on when considering this aspect in a new therapy payment system. APTA advocates for consistency of a therapy payment model across all post-acute care such as home health, inpatient rehabilitation, long-term care and SNFs as well as outpatient settings to ensure that continuity of care in the most appropriate setting to treat the complexity and severity of the patient is optimized.

In this next phase of the SNF Therapy Payment Project, APTA urges CMS and Acumen to integrate the following considerations:

1. The model should facilitate and promote the use and reporting of standardized patient assessment instruments, quality measures, electronic health records, and participation in national registries to provide essential data that will improve the model over time.
 - The methodology should incorporate the World Health Organization's International Classification of Function framework to the extent possible and applicable.
 - The model should include quality measures that foster shared accountability among providers throughout the continuum of care, specifically regarding readmissions and chronic care management.
 - The model should include a core set of functional items to be reported across PAC settings that can be imbedded into existing assessment tools such as the Minimum Data Set 3.0 (MDS 3.0), Outcomes Assessment Information Set (OASIS C), and IRF Patient Assessment Instrument (IRF-PAI) to promote uniformity.
2. The model should recognize the clinical reasoning and decision making by the physical therapist's evaluative process in addition to planned interventions and allow for seamless transition amongst post-acute care settings. It should be amenable to account for any setting specific considerations that must be considered to ensure quality care and efficient administrative processes.
 - The model should promote interdisciplinary communication to enhance quality and foster care management.
 - The model should adequately account for proper treatment, discharge and transition planning.
3. The model should promote and encourage accurate reporting and appropriate payment of services and include specific payment considerations based on unique setting needs and resources.

- The model should incorporate the severity of the patient’s condition and the intensity of therapy services needed for treatment.
 - The payment model should be weighted based on the severity of the patient and the complex resources need to treat the patient and usher in the elimination of the current arbitrary payment thresholds and stipulations dictated by the number of therapy visits and minutes of therapy provided.
4. There should be education and outreach to providers and Medicare contractors to ensure seamless implementation.
 5. The model should take an incremental approach to implementation that may take place over several years that allows for adequate testing and adjustment for risk factors prior to full implementation.

In coordination with Acumen’s exploration and stated intent to use assessment items from the PAC-PRD, APTA’s recommends the following core item set be collected as part of the SNF Therapy Project:

1) Self-Care

- a. Eating – The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table or tray. Includes modified food consistency.
- b. Tube feeding- The ability to manage all equipment and supplies for tube feeding. Recommend that this be collected as a yes or no response.
- c. Oral Hygiene – The ability to use suitable items to clean teeth. Dentures: The ability to remove and replace dentures from and to mouth, and manage equipment for soaking and rinsing.
- d. Toilet Hygiene - Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after using toilet, commode, bedpan, urinal.
- e. Upper Body Dressing - The ability to dress and undress above the waist, including fasteners. Wash upper body: The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.
- f. Lower Body Dressing - Lower body dressing: The ability to dress and undress below the waist, including fasteners. Does not include footwear. Does not include hospital gown.

2) Mobility

- a. Lying to Sitting - The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.
- b. Sit to Stand - The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
- c. Chair/Bed to Chair Transfer - The ability to safely transfer to and from a chair (or wheelchair). The chairs are placed at right angles to each other.

- d. Longest Distance Patient Can Walk - Once standing, can walk at least 150ft, walk at least 100ft, walk at least 50ft, or walk at least 10 feet (3 meters) in corridor or similar space.¹
- e. Longest Distance Patient Can Wheel - Once seated, can wheel at least 150ft, wheel at least 100ft, wheel at least 50ft, or wheel at least 10 feet (3 meters) in corridor or similar space.²

Lastly, in the proposed rule, CMS states that portions of the SNF Therapy Project may be implemented in subsequent rulemaking prior to the promulgation of a final new payment model. APTA strongly urges CMS to continually engage providers and other stakeholders in any proposals to implement portions of this work prior to their publication in a Notice of Proposed Rulemaking (NPRM). We believe that any future proposals should be given thorough and adequate consideration by providers and stakeholders, and we are concerned that the 60 day rulemaking period is not a sufficient timeframe to appropriately examine the effect of any proposed changes.

Proposed Revisions to Policies Related to the COT OMRA

CMS proposes to revise the COT OMRA policy to allow SNFs to complete a COT OMRA for a patient who is not currently classified into a RUG-IV therapy group or receiving a level of therapy sufficient for classification into a RUG-IV therapy group in certain cases. This proposed revision is limited to those isolated cases where the resident had qualified for a RUG-IV therapy group on a prior assessment during the SNF stay and had no discontinuation of therapy services between Day 1 of the COT observation period for the COT OMRA that classified the patient into the current non-therapy RUG-IV group and the ARD of the COT OMRA that reclassified the patient into a RUG-IV therapy group. The COT OMRA cannot be used to initially qualify the patient into a therapy RUG. CMS does not believe that this revision will reflect a common occurrence and states that they will monitor its effects if finalized.

APTA commends the Agency for its recognition of the inability of SNFs to utilize the COT OMRA in these situations and fully supports the adoption of this proposal in the final rule. APTA wholeheartedly shares CMS' desire to ensure payment accuracy for therapy services under the SNF PPS. Therefore, this revision is critical in improving the applicability of the COT OMRA. In coordination with the final rule, APTA requests that CMS provide educational resources to providers such as a Frequently Asked Question document and MLN article to fully explain how this change will affect SNF discharge planning processes, scheduled and unscheduled assessments as well as the End of Therapy (EOT) OMRA and the End of Therapy Resumption (EOT-R) OMRA.

Accelerating Health Information Exchange in SNFs

CMS notes the importance of the adoption and spread of health information exchanges in the SNF environment and across the care continuum and highlights the important work that the federal government has undertaken in recent years. APTA is committed to advancing the safety and quality of healthcare through health information technology (HIT) innovation and we are

¹ This should be a temporal component which includes age specific norm time spent to walk X distance and cap time at this amount.

² Id

eager to work with the CMS, the Office of the National Coordinator for Health Information Technology (ONC) and other governmental agencies on health information technology's evolving role in promoting health, health care reform and health information exchange.

APTA is committed to the adoption of electronic health records (EHR), implementation and enforcement of privacy and security protections, and utilization of electronic health information to support new payment models such as accountable care organizations, as well as fostering health information exchange where it is not currently taking place, supporting coordinated patient-centered quality care through utilization of electronic health information, and being an active participant in the evolution of an interconnected electronic health system. APTA has many member physical therapists who have implemented electronic health record systems in their practices, despite not being defined as "eligible providers" (EPs) to receive meaningful use incentives under the Medicare and Medicaid programs.

Physical therapists play a critical role in a patient's continuity of care as the patient transitions from one health care setting to another. Physical therapy services are provided in a variety of settings, including home care, hospitals, outpatient clinics or offices; inpatient rehabilitation facilities; skilled nursing, extended care, sub-acute facilities; Intermediate Care Facilities for People with Mental Retardation (ICF/MR); patients' education or research centers, hospices and schools. Physical therapy efficiently aids a beneficiary in gaining the best possible function within the context of their medical condition. These services ensure the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health.

With this expertise, physical therapists are essential participants in health care integration. Their assessment and plan of care for the patient is critical to reducing complications, particularly in the LTPAC community and, therefore, it is important that information from each care team member at the varying settings is captured and exchanged based on the specialist's area of expertise to optimize patient outcomes and reduce miscommunication among the varying providers the patient will see throughout the course of care.

In conclusion, APTA thanks CMS for the opportunity to comment on the Skilled Nursing Prospective Payment System proposed rule (FY 2014), and we look forward to working with the agency to craft patient-centered payment policies that reflect quality health care for all Medicare beneficiaries. If you have any questions regarding our comments, please contact Roshunda Drummond-Dye, Director of Regulatory Affairs, at (703) 706-8547 or roshundadrummond-dye@apta.org.

Sincerely,

A handwritten signature in black ink that reads "Paul Rockar Jr." in a cursive script.

Paul Rockar, Jr. PT, DPT, MS
President

PR: rdd